FULL DENTAL
Health History

Patient Name: _____ Date: _____

Age: _____ Sex: M_____ F _____ Height: _____ Weight: _____

In case of emergency, contact: _____ Phone #: ( )_____

- **Instructions:**

Answer all questions and fill in the blank spaces when indicated.

Answer to the following questions are for our records only and will kept confidential.

Why are you here today? _____
When was your last visit to a dental office? _____/_____/_____
When were your last dental X-rays taken? _____/_____/_____
Are those X-rays available? YES_____ NO _____
If YES please write down PRIOR DENTIST'S NAME and PHONE NUMBER
_____ ( )_____

1. Are you in poor health? . . . . . YES _____ NO _____
2. Has there been any change in your general health within the past year? . . . . . YES _____ NO _____
3. My last physical was on . . . . . _____/_____/_____
4. Are you currently under the care of a physician . . . . . YES _____ NO _____
    a. If so, what is the condition being treated _____
5. The name and address of my physician is _____
6. Have you had any serious illness or operation? . . . . . YES _____ NO _____
    a. If so, what was the illness or operation? _____
7. Have you been hospitalized or had serious illness within the past five years? . . . . . YES _____ NO _____
    a. If so, what was the problem? _____
8. Do you have or have you had any of the following diseases or problems?
    a. Damaged heat valves or artificial heart valve . . . . . YES _____ NO _____
    b. Congenital heart lesions or murmurs . . . . . YES _____ NO _____
    c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) . . . . . YES _____ NO _____
        - Do you have pain in chest upon exertion . . . . . YES _____ NO _____
        - Are you ever short of breath after mild exercise . . . . . YES _____ NO _____
        - Do your ankles swell . . . . . YES _____ NO _____
        - Do you get short of breath when you lie down, or do you require extra pillows when you sleep . . . . . YES _____ NO _____
        - Do you have cardiac pacemaker . . . . . YES _____ NO _____
    d. Sinus trouble . . . . . YES _____ NO _____
    e. Asthma . . . . . YES _____ NO _____
    f. Allergy. . . . . YES _____ NO _____
    g. Hives or Skin rash . . . . . YES _____ NO _____
    h. Fainting spells or seizures . . . . . YES _____ NO _____
    i. Diabetes . . . . . YES _____ NO _____
        - Do you urinate (pass water) more than 6 times a day . . . . . YES _____ NO _____
        - Are you thirsty much of the time . . . . . YES _____ NO _____
        - Does your mouth frequently become dry . . . . . YES _____ NO _____
    j. Hepatitis, jaundice or liver disease . . . . . YES _____ NO _____
    k. Arthritis. . . . . YES _____ NO _____
    l. Inflammatory rheumatism (painful, swollen joints) . . . . . YES _____ NO _____
    m. Stomach ulcers . . . . . YES _____ NO _____
    n. Kidney trouble . . . . . YES _____ NO _____
    o. Tuberculosis . . . . . YES _____ NO _____
    p. Do you have a persistent cough or cough up blood . . . . . YES _____ NO _____
    q. Low blood pressure . . . . . YES _____ NO _____
    r. Venereal disease . . . . . YES _____ NO _____
    s. Do you have prosthetic hip _____ joint prosthesis _____ implants _____ bone plates _____ or screws _____
    t. other _____

9. Have you had abnormal bleeding associated with previous extractions, surgery or trauma . . . . . YES _____ NO _____
    a. Do you bruise easily . . . . . YES _____ NO _____
    b. Have you ever required a blood transfusion . . . . . YES _____ NO _____
    c. If so, explain the circumstances _____
10. Do you have any blood disorder such as anemia . . . . . YES _____ NO _____
11. Have you have surgery or X-rays treatment for a tumor, growth or other condition of your mouth lips . . . . . YES _____ NO _____
12. Are you taking any of the following . . . . . YES _____ NO _____
    If yes indicate which.

Antibiotics or sulfa drugs	_____	Anticoagulants (blood thinners)	_____
Medicine for high blood pressure	_____	Cortisone (steroids)	_____
Antihistamine	_____	Aspirin	_____
Tranquilizers	_____	Insulin, tolbutamide (orinase) or similar drugs	_____
Digitalis or drugs for heart trouble	_____	Nitroglycerin	_____
Oral contraceptive or other hormonal therapy	_____	Other drug or medicine	_____

13. Are you allergic or have you reacted adversely to any of the following . . . . . YES _____ NO _____

Local anesthetics	_____	Penicillin or other antibiotics	_____	Sulfa drugs	_____
Barbiturates, sedatives or sleeping pills	_____	Aspirin	_____	Iodine	_____
Codeine or other narcotics	_____	Are you allergic to latex or rubber products			_____

    Other allergies _____
14. Have you taken the diet medication Redux® (Fen-Phen)? . . . . . YES _____ NO _____
15. Do you have any disease, condition or problem not listed above that you think I should know about . . . . . YES _____ NO _____
16. Are you employed in any situation which exposes you regularly to X-rays or other ionizing radiation . . . . . YES _____ NO _____
17. Are you wearing contact lenses . . . . . YES _____ NO _____
18. Have you ever had any of the following conditions . . . . . YES _____ NO _____
    a. Herpes_____ Hepatitis _____ Tuberculosis _____ HIV / AIDS _____
19. Are you pregnant . . . . . YES _____ NO _____
20. Do you have any problems associated with your menstrual period . . . . . YES _____ NO _____
21. Are you nursing . . . . . YES _____ NO _____
22. Have you had any serious trouble associated with any precious dental treatment . . . . . YES _____ NO _____
    If so, explain _____
23. How often do you brush your teeth? _____
24. Do you use dental floss? . . . . . YES _____ NO _____
25. Do your gums bleed or hurt . . . . . YES _____ NO _____
    How often_____
26. Are any of your teeth sensitive to: Hot_____ Cold _____ Sweets_____ Pressure_____
27. Does food get caught on your teeth? . . . . . YES _____ NO _____
28. Do you have frequent headaches_____ neck aches _____ Shoulder ache? _____
29. Do you clench or grind your teeth? . . . . . YES _____ NO _____
30. Have you experienced any pain or soreness in the muscles of your face or around ear . . . . . YES _____ NO _____
31. Does your jaw click or pop? . . . . . YES _____ NO _____

I hereby certify that I have read the foregoing and have filled out this health questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the undersigned, consent to the performing of x-rays and examination.

_____	_____	_____	_____
Signature of patient or guardian	Date	Signature of Dentist	Date